months, but without pain or hemorrhage. A bony adhesion was found between the inferior turbinate and the septum, which was removed with the trephine. Recurrence ensuing a few weeks later, the core of tissue was removed with the trephine and found by Dr. Jonathan Wright to be an osteosarcoma. Further treatment was not allowed.

Angiofibroma of the Nose.—This case was reported by DR. NEWCOMB (*Ibid.*), which occurred in an Irish-American, aged twenty years, who for seven months had complained of alternating nasal obstruction, finally becoming permanent, on the left side. Inspection revealed an apparent polyp hanging from the middle turbinate, but posterior rhinoscopy disclosed a mass in the rhinopharynx, apparently blocking the left side only. The anterior growth was so hard that it resisted the cold wire snare, bleeding freely. A small portion removed with considerable hemorrhage, which was checked with difficulty, was found microscopically to be an angiomatous fibroma. Its point of origin could not be determined, and the patient refused further surgical interference.

Nasal Polypi the Cause of Atrophy of the Optic Nerves.—At a recent meeting of the French Society of Ophthalmology (*Archives de Médécine et de Chirurgie Speciales*, May, 1902), DR. PARISOTTI reported a case of a young man, aged twenty-five years, whose vision rapidly diminished to 1/50 on the right and 1/10 on the left, the papillæ becoming pale and almost on the point of being completely blanched. Rhinoscopic examination was at first negative, but subsequently revealed hypertrophy of the turbinates, and polypoid vegetations of the middle meatus. After the ablation of these growths vision increased progressively, so that five months later it equalled I in both eyes, the papillæ remaining very white. Six months later, however, vision had receded to 4/10. The author attributes these optic troubles to a spasmodic ischæmia produced by the nasal vegetations.

Foreign Body in the Larynx.—DR. OLIVER A. BLUMENTHAL, of Syracuse, N. Y., reports (*American Medicine*, August 30, 1902) a case of a triangular fragment of bone one and one-half inches long impacted in the larynx; the sharp-pointed end was in the left arytenoepiglottic fold and the broad end in the right fold. The bone was released and extracted with laryngeal forceps under guidance by the laryngoscopic mirror.

Morbid Growths of the Larynx.—DR. JOSEPH D. BRYANT, of New York, reports (*Journal of the American Medical Association*, October 18, 1902) an interesting case in a patient, aged forty-five years, of a large tumor of the posterior wall of the larynx low down, removed by enucleation after external access by low lateral pharyngotomy. It weighed 425 grains, and was 1⅝ x 1¾ x 1½ inches in its antero-posterior, vertical, and transverse diameters, respectively. Muscular fibres were found in the structure, leading to the surmise that it must have originated in muscular tissue. The lateral pharyngotomy was selected because digital exploration had revealed an apparent attachment of the tumor to the right portion of the pharyngeal wall. When exposed to digital exploration through the external wound, the growth was found quite immovable and apparently firmly attached to the posterior wall of the pharynx. The finger, introduced through an incision between the tumor and the mucous membrane covering it, completely enucleated the growth, leaving its entire membranous envelope intact. The patient made a good recovery. A number of somewhat similar instances were reported by gentlemen who took part in the discussion of this paper before the Section on Surgery and Anatomy of the American Medical Association at its fifty-third annual meeting.

Foreign Bodies in the Air Passages: Escape of the Outer Tube of a Durham Tracheal Canula.—DR. E. D. FERGUSON, of Troy, N. Y., reports (*New York State Journal of Medicine*, October, 1902) the escape into the right bronchus of the outer tube of a Durham double canula in consequence of the neglect of the manufacturer to provide it with the necessary protective flange at its outer extremity. Its removal was effected by incising the tracheal wall down toward the bifurcation, when, with the finger, the missing tube was felt in the right bronchus, the upper extremity being well within the bronchus. With the aid of illumination from a head mirror the upper edge of the tube was seen, and it was removed with forceps.

PATHOLOGY AND BACTERIOLOGY.

UNDER THE CHARGE OF
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Multiple Progressive Hyaloserositis (*Studies from the Royal Victoria Hospital*, Montreal, vol. i., No. 3).—Under the foregoing title NICHOLS discusses the etiology, morbid anatomy, and clinical aspects of that form of a chronic proliferative process affecting serous surfaces "characterized by the formation of a membrane composed of dense layers of connective tissue of a peculiar cartilaginous appearance." This membrane, which may be several centimetres in thickness, is a continuous stratified layer, and can be peeled off from the subjacent affected organs. The upper part of the peritoneum, particularly the liver and spleen capsules, the bases of the pleural cavities, and the pericardium are the parts oftenest involved. As a result, the structures attacked may show atrophic, degenerative, or even fibroid changes.

As a localized liver lesion the process has been described as chronic hyperplastic perihepatitis, chronic deforming perihepatitis, and by Curschmann as